

Statement of Insurability

Instructions

1. The Statement of Insurability form may already show your Employer's Name, Group Number and Location (if applicable). Check with your Benefits Administrator if this information is missing. We cannot process the statement without it.
2. If you are applying for Life coverage, your Benefits Administrator may complete the section of the form regarding Current Amount, Total Amount Desired (including your current amount and any guaranteed amount, if applicable) and the Amount to be Underwritten or he/she should give you instructions on what the amounts should be. **If you have a question regarding the amount that requires underwriting, please contact your Benefits Administrator.**

IMPORTANT:

The "amount to be underwritten" is the dollar amount of coverage for which you or your dependents must show proof of good health. This "underwritten" amount should NOT include any coverage you or your dependents already have in force through this plan or any coverage that can be obtained through this plan without providing proof of good health. If the amount to be underwritten is incorrectly stated on your Statement of Insurability form, you or your spouse may be asked to have an exam, blood profile or EKG that might otherwise not be necessary. Note: If there is no current coverage in force, a zero "0" should be put in that column. Current, total and underwritten amounts need only be indicated on this Statement of Insurability for the family members who are applying for coverage at this time.

3. Please make sure you've provided all requested information, answered all questions and that you've signed and dated the form. Failure to do so may result in the form being returned to you, which will delay processing time.
4. Make a copy of the form for your records. Also, Read the Insurance Information Practices Notice page and keep it for your reference.
5. After completing the Statement of Insurability form, follow the instructions given to you by your Benefits Administrator. If you are instructed to mail the form directly to us, please use the "Return form to" address on the last page of this form.

United HealthCare Insurance Company Insurance Information Practices Notice

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Statement of Insurability Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your Statement of Insurability Form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with United HealthCare Insurance Company or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. United HealthCare Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112.

United HealthCare Insurance Company, or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**United HealthCare Insurance Company
Statement of Insurability**

Employer TOWN AND BOARD OF EDUCATION OF MANCHESTER	Group # 300602	Location (mark one) <input type="checkbox"/> Town – Subgroup 1002 <input type="checkbox"/> B.O.E. – Subgroup 1003
Employee Name	Employee Social Security No.	
Address	City, State, Zip	
Employee Date of Birth	Home Phone #	Work Phone #
Hire Date	Annual Salary	

Persons Proposed for Coverage (list Employee Information first):

NAME FIRST, M.I., LAST	RELATIONSHIP TO EMPLOYEE	SEX M/F	BIRTH DATE MM/DD/YY	HEIGHT FT, IN	WEIGHT LBS

For life coverages, enter the dollar amount of current coverage (including any guaranteed issue amount, if applicable), the total dollar amount desired and the dollar amount of the difference between the total amount desired and the current amount which requires proof of good health at this time (i.e. needs to be medically underwritten).

	Product(s) Being Underwritten						
	Basic Life	Supplemental Life	Current Life Amount	Total Life Amount Desired	Life Amount to be Underwritten	Short Term Disability	Long Term Disability
Employee			\$	\$	\$	N/A	N/A
Spouse	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dependent #1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dependent #2	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This Statement of Insurability is being submitted due to: New Hire ____ Late Entrant ____ Increase ____ Other ____

If other, please explain: _____

The following questions apply to all persons proposed for coverage:

- Within the past 10 years has any person proposed for coverage ever been medically treated or medically diagnosed with:
 - Yes No Diabetes or sugar, albumin or blood in the urine: If Yes, when first diagnosed? _____
 - Yes No High blood pressure, chest pain, heart murmur, shortness of breath, angina or other heart or circulatory disorder?
 - Yes No Stroke, epilepsy, fainting, dizziness, headaches or any disorder of the brain or nervous system?
 - Yes No Tuberculosis, asthma, hay fever, lung or respiratory disorder?
 - Yes No Stomach or duodenal ulcer, other ulcer, colitis, disorder of gall bladder, liver, stomach or intestines?
 - Yes No Varicose veins, varicose ulcers, or phlebitis or hernia of any kind?
 - Yes No Kidney, bladder or prostate disorder or other urinary disorder?
 - Yes No Tumor or disease or dysfunction of the breast, reproductive organs or abnormal menstrual period?
 - Yes No Arthritis, rheumatism or any disorder of the joints, muscles, back or bones?
 - Yes No Cancer or tumor or ulcer of any kind, growth or cyst?
 - Yes No Any disorder of eyes, ears, nose or throat?
 - Yes No Alcoholism, narcotic addiction?
 - Yes No Nervous or mental disorder (including professional counseling)?
 - Yes No Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)?
- Has any person proposed for coverage:
 - Yes No Had any life or health insurance declined, postponed or modified, or had a waiver or extra premium added?
 - Yes No Been released from the military for medical reasons?
 - Yes No Received payment for disability, illness or injury?

- d) Yes No Had a change of weight of more than 10 pounds in the last 12 months? If Yes, state name of person(s), reason(s) and amount(s) of gain/loss in Detail Section below.
3. Within the past 5 years, has any person proposed for coverage:
- a) Yes No Had abnormal findings of a physical examination, electrocardiogram, X-ray, blood test or diagnostic test?
- b) Yes No Had inpatient or outpatient surgery?
- c) Yes No Been advised to have surgery not yet done?
- d) Yes No Had any medical treatment, health or physical impairment, condition or congenital anomaly not mentioned above?
4. Yes No Have medications been prescribed to any person proposed for coverage for any reason in the last 12 months? If Yes, please list medication name, dose, dates used and condition used for in Detail Section below.
5. Yes No Are any persons to be covered pregnant?
If Yes: Name of person _____ Expected delivery date: _____

**DETAIL SECTION - GIVE FULL DETAILS FOR EACH "YES" ANSWER IN QUESTIONS 1 – 4 ABOVE
IF MORE SPACE IS NEEDED, ATTACH A SEPARATE PIECE OF PAPER, SIGNED AND DATED.**

Name of Person	Question No.	Dates of Treatment	Diagnosis, Degree of recovery	Name, Address, Phone # of Attending Physician

NAME, ADDRESS AND PHONE # OF PRIMARY CARE PHYSICIAN OF PERSONS PROPOSED FOR COVERAGE:

	EMPLOYEE	SPOUSE	CHILDREN
DOCTOR NAME			
STREET ADDRESS			
CITY, STATE, ZIP			
PHONE NUMBER			

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby declare that all the statements made above and on the reverse side are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, Insurance company or its reinsurer, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, or that of any member of my family whose name appears in the application to which this is attached to give United HealthCare Insurance Company (“UHIC”), and its affiliates any such information. This information will be used to determine eligibility for insurance. I understand that I may revoke this authorization at any time by sending a written revocation to UHIC at the address below. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right UHIC has to contest an insurance policy/certificate, or to contest a claim under an insurance policy/certificate. I understand that if I revoke this authorization, UHIC may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 30 months from the date signed. I also understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and may be subject civil penalties, criminal penalties and/or the denial of insurance benefits.

Employee Signature _____ Date _____

Spouse Signature (if applying for coverage) _____ Spouse SS#: _____

**Return form to:
Unimerica Workplace Benefits, Group Medical Underwriting Services, PO Box 17829, Portland, ME 04112**